NSN 7540-00-634-4127

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: *(Requesting physician or activity)*	DATE OF REQUEST

REASON FOR REQUEST *(Complaints and findings)*

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
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